STATE OF MAINE

BOARD OF COUNSELING PROFESSIONALS LICENSURE

APPLICATION FOR PASTORAL COUNSELING LICENSURE

Department of Professional and Financial Regulation
Office of Licensing and Registration
35 State House Station
Augusta, ME 04333-0035

Office Telephone: (207) 624-8674
Office Facsimile: (207) 624-8637
HEARING IMPAIRED (888) 577-6690
E-mail: colleen.a.eugley@maine.gov

Office located at: 122 Northern Avenue, Gardiner, Maine

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
(888) 577-6690 (HEARING IMPAIRED)

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

Dear Applicant:

The application material you have requested from the Board of Counseling Professionals Licensure is enclosed. It contains all of the information you will need to complete your application. **Please read the forms, the laws and the rules carefully**. Follow the directions in the rules for licensure eligibility requirements appropriate to the category of license for which you are applying. Do not rely solely on the applicant information sheet enclosed. This document is intended to be just a quick checklist and is furnished for your convenience.

If you have questions about the application package you are about to send to us, please feel free to call our office. However, once you have submitted your application, we ask that you refrain from calling the office to inquire about the status of your application. If the application package you submit to us is complete, it will be prepared and presented to the board for official action. If there are deficiencies about your application, it will be returned to you together with a notice that your application is incomplete for the reasons noted. Any application received by the board must be complete before the Board will review it. **If all components of the application are not complete 10 days prior to the Board meeting the application will not be reviewed at that Board meeting.** Due to the volume of applications being reviewed by the board at any given time, we cannot guarantee a particular review date, but the board will endeavor to expedite the review of your application.

Results of the board's action will not be provided by phone. Therefore, we ask that you refrain from calling our office after the meeting to receive telephone results of board actions. You will be notified, in writing, within two weeks of the board meeting, of the board's decision regarding your application. Calling our office will cause a delay in notifications being prepared for mailing. We appreciate your thoughtful attention to this request.

We wish you well with your application for Maine licensure, and look forward to receiving your material soon.

Sincerely,
Board of Counseling Professionals Licensure

OFFICE PHONE: (207)624-8674

FAX: (207)624-8637

(888) 577-6690 (HEARING IMPAIRED)
OFFICES LOCATED AT: 122 NORTHERN AVENUE,
GARDINER, MAINE

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
(888) 577-6690 (HEARING IMPAIRED)

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

LICENSURE – FULL / CONDITIONAL APPLICATION

(SEE CHAPTERS 2 -6 OF THE BOARD'S RULES FOR REQUIREMENTS)

A COMPLETE APPLICATION SHALL INCLUDE THE FOLLOWING:

- ❒ Completed and Signed Application Form. (Attachment 1)
- ❒ Application fee of $100.00.
- ❒ License fee: Permanent License Fee $300.00 / Conditional License Fee $150.00.
- ❒ Criminal History fee of $15.00
- ❒ Official Transcript - forwarded directly to the Board by the academic institution holding the transcript.
- ❒ Verification of Internship – form completed by university that attests to the number of internship hours, and also describes the counseling activities, setting, and supervisor credentials of the internship experience. (Attachment 8).
- ❒ Applicants for **Full Licensure** must submit Completed Supervisor's Affidavit forms. (Attachment 6).
- ❒ Applicants for **Conditional Licensure** must submit a Proposed Supervision Plan using the enclosed form. (Attachment 7)
- ❒ Reference Forms - 3 forms to be completed by professionals in the counseling field and dated within one year prior to the date of application. (Attachment 5)
- ❒ Official proof of a passing score on an examination as prescribed in the Rules - forwarded to the Board directly by the organization holding the test scores or a request for examination. (Attachment 10) **If you are requesting to sit for the exam, please indicate test date on enclosed form**.
- ❒ A copy of your Disclosure Statement. (Attachment 16)
- ❒ Education Worksheet for appropriate license applied for - Applicant must also submit a course brochure/catalog which describes courses. (Attachment 12, 13, 14, or 15)
- ❒ Applicants for licensure as a Pastoral Counselor must also submit proof of call, appointment or charge by a church, synagogue, religious order or other clearly defined legal religious organization to perform these services as a function of ministry.

(NOTE: FEES CAN BE COMBINED AND SUBMITTED AS ONE PAYMENT. IF YOU ARE PAYING BY MONEY ORDER OR BY CHECK, PLEASE MAKE PAYABLE TO: TREASURER, STATE OF MAINE.)

LICENSURE – LICENSED IN ANOTHER JURISDICTION APPLICATION

INSTRUCTIONS FOR APPLICANTS LICENSED IN ANOTHER JURISDICTION

(SEE CHAPTER 6 OF THE BOARD'S RULES)

There are three pathways to licensure as outlined below:

Pathway 1: Reciprocal agreement between the State of Maine and another jurisdiction*, or

Pathway 2 – Substantially Equivalent License: Applicant submits evidence of 5 years actively practicing with a substantially equivalent license immediately preceding application that is in good standing, or

Pathway 3 – Substantially Similar Qualifications: Applicant's qualifications are substantially similar to Maine's licensing requirements with a license that is in good standing.

*Currently, the State of Maine Board of Counseling Professionals Licensure has not entered into any reciprocal agreements with other jurisdictions. Therefore, applicants should submit their application according to either Pathway 2 or Pathway 3 if already licensed in another jurisdiction.

PATHWAY 2 APPLICATIONS SHALL INCLUDE THE FOLLOWING:

- ❒ Completed and Signed Application Form. (Attachment 1)
- ❒ Application fee of $100.00.
- ❒ License fee: Permanent License Fee $300.00.
- ❒ Criminal History fee of $15.00.
- ❒ Official Transcript - forwarded directly to the Board by the academic institution holding the transcript.
- ❒ Three reference forms completed by professionals in the counseling field and must be dated within one year prior to the date of application. (Attachment 5)
- ❒ A copy of the relevant licensing law and Board rules of the licensing or certifying state of jurisdiction from which you are applying.
- ❒ A copy of all mental health licenses under which applicant practiced during the 5 consecutive years.
- ❒ Verification of mental health licensure from the jurisdiction(s) in which the applicant was ever licensed. (Attachment 7)
- ❒ A copy of your disclosure statement. (Attachment 11)
- ❒ A resume and summary of applicant's licensed mental health practice.

PATHWAY 3 APPLICATIONS SHALL INCLUDE THE FOLLOWING:

- ❒ Completed and Signed Application Form. (Attachment 1)
- ❒ Application Fee of $100.00.
- ❒ License Fee: Permanent License Fee $300.00.
- ❒ Criminal History fee of $15.00.
- ❒ Official Transcript - forwarded directly to the Board by the academic institution holding the transcript.
- ❒ Three reference forms completed by professionals in the counseling field and must be dated within one year prior to the date of application. (Attachment 5)
- ❒ Verification of Internship – form completed by university that attests to the number of internship hours, and also describes the counseling activities, setting, and supervisor credentials of the internship experience. (Attachment 8).
- ❒ Education Worksheet for appropriate license applied for - Applicant must also submit a course brochure/catalog which describes courses. (Attachment 12, 13, 14, or 15)
- ❒ Completed Supervisor's Affidavit forms. (Attachment 6).
- ❒ Official proof of a passing score on an examination as prescribed in the Rules - forwarded to the Board directly by the organization holding the test scores or a request for examination. (Attachment 10) **If you are requesting to sit for the exam, please indicate test date on enclosed form**.
- ❒ A copy of all mental health licenses under which applicant practiced.
- ❒ Verification of all mental health licenses in other states. (Attachment 9)
- ❒ A copy of your disclosure statement. (Attachment 16)

(NOTE: FEES CAN BE COMBINED AND SUBMITTED AS ONE PAYMENT. IF YOU ARE PAYING BY MONEY ORDER OR BY CHECK, PLEASE MAKE PAYABLE TO: TREASURER, STATE OF MAINE.)

IF YOU ARE CURRENTLY CONDITIONALLY LICENSED AND ARE APPLYING FOR FULL LICENSURE YOU MUST INCLUDE THE FOLLOWING:

- ❒ Completed and signed Application. (Attachment 1)
- ❒ Application fee of $100.00.
- ❒ License fee of $300.00.
- ❒ Submission of evidence of completing the required continuing education activities for current conditional licensing cycle.
- ❒ A copy of your Disclosure Statement. (Attachment 16)
- ❒ Completed Criminal History Form and $15.00 fee. (Attachment 3)
- ❒ Completed and signed Supervisor's Affidavit's Form. (Attachment 6)

PLEASE NOTE:

If you are submitting an application for full licensure near the expiration date of your conditional license, you should include a completed and signed **renewal application** in your application packet to the board. The inclusion of your renewal application is intended to avoid a potential gap in licensure between your conditional license and the board's approval of your application for full licensure. In the event that your renewal application needs to be processed, you will be contacted by the board and will be requested to pay the renewal fee before the renewal application is processed.

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
(888) 577-6690 (HEARING IMPAIRED)

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

APPLICATION FOR LICENSURE

****

A LICENSE FEE & AN APPLICATION FEE ARE REQUIRED FOR EACH LICENSE APPLIED FOR

(Make Checks Payable to: Treasurer, State of Maine)

Notice regarding Social Security Number Disclosure	**Notice regarding Public Information**
The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.	This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, mailing address and other information listed on this application may be posted on the State's website.

CHECK APPROPRIATE CATEGORY:

Pastoral Counselor

- ☐ Standard
- ☐ Conditional
- ☐ Other Jurisdiction

PERSONAL INFORMATION:

Pursuant to 5 M.R.S.A. §5301-5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration **requires** a criminal history records check as part of the application process for all applicants. Please indicate below any alias or maiden names accordingly.

Name _____ S.S. # _____-_____-_____

Mailing Address _____ City _____

State _____ Zip Code _____ County _____

Daytime Telephone ( ) _____ Date of Birth _____

WORK INFORMATION:

Workplace _____

Street/P.O. Box _____ City _____ State _____

Zip Code _____ Work Telephone ( ) _____

EDUCATION: (Official transcripts must be submitted directly from Institution)

Institution Name & Address _____

Degree Granted & Date Conferred _____

Institution Name & Address _____

Degree Granted & Date Conferred _____

Institution Name & Address _____

Degree Granted & Date Conferred _____

COUNSELING EXPERIENCE:

1. Workplace Name_____

Address_____

Dates Employed _____

2. Workplace Name_____

Address_____

Dates Employed _____

3. Workplace Name_____

Address_____

Dates Employed _____

SUPERVISORS: (Applicants for Conditional license must submit a written plan for completing supervision)

Name_____

Address _____
Name_____

Address _____

CREDENTIALING HISTORY: **(If you answer YES on any of #2 - #5, please attach an explanation of each on a separate sheet)**

1. Have you ever held a professional license/certification/registration in this or any other state/country? [ ] YES [ ] NO

If yes, what profession?_____

Where? _____ Expiration Date _____

2. Has your license/certification/registration or professional membership ever been disciplined? [ ] YES [ ] NO

3. Have you ever been convicted of a crime other than a minor traffic violation? [ ]YES [ ]NO

If yes, please describe in detail the date(s), crime(s) and submit a copy of the court judgment(s) as well as a letter from you explaining the circumstances surrounding your conviction.

4. Do you have pending against you any complaints from a regulatory board or professional organization? [ ] YES [ ] NO

5. Have you ever been or are you currently a defendant in a civil proceeding related to your professional activities? [ ] YES [ ] NO

6. Have you ever taken a Counseling Examination? [ ] YES [ ] NO

If yes: Where? _____ Which Exam? _____ Date Taken? _____

LICENSED IN ANOTHER JURISDICTION: **(See Chapter 6 of the Board Rules)**

License Issue Date _____ State/Country _____

Issuing Authority _____

Have you taken a qualifying examination in any other state? [ ] YES [ ] NO

If yes: Where? _____ Which Exam? _____ Date Taken? _____

I HAVE READ AND COMPLETED THIS APPLICATION AND I ATTEST THAT ALL INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I ALSO AGREE TO FOLLOW THE CODE OF ETHICS AS APPROVED BY THE BOARD.

SIGNED _____ DATE _____

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
(888) 577-6690 (HEARING IMPAIRED)

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

ACCOMMODATION REQUEST FORM

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission.

NAME:_____

ADDRESS:_____

PHONE: ( ) _____ SOCIAL SECURITY # _____

ACCOMMODATIONS REQUESTED FOR THE _____EXAMINATION
(CHECK ALL THAT APPLY)

- ☐ ACCESSIBLE TESTING SITE
- ☐ SEPARATE TESTING AREA
- ☐ BRAILLE
- ☐ LARGE PRINT
- ☐ TAPE
- ☐ READER AS ACCOMMODATION FOR VISUAL IMPAIRMENT
- ☐ SCRIBE/AMANUENSIS AS ACCOMMODATION FOR VISUAL OR MOTOR IMPAIRMENT
- ☐ READER AS ACCOMMODATION FOR LEARNING DISABILITY
- ☐ SCRIBE/ANANUESIS AS ACCOMMODATION FOR LEARNING DISABILITY
- ☐ SIGN LANGUAGE INTERPRETER
- ☐ EXTENDED TIME
- ☐ TIME-AND-A-HALF
- ☐ DOUBLE TIME
- ☐ MORE THAN DOUBLE TIME(SPECIFY):_____
- ☐ USE OF COMPUTER OR OTHER ADAPTIVE EQUIPMENT (SPECIFY):_____
- ☐ OTHER_____

COMMENTS:_____

_____

SIGNED:_____DATE:_____

SOME ACCOMMODATION REQUESTS MAY REQUIRE ADDITIONAL DOCUMENTATION
(see page 2)

OFFICE PHONE: (207)624-8674

PRINTED ON RECYCLED PAPER

FAX: (207)624-8637

(888) 577-6690 (HEARING IMPAIRED)
OFFICES LOCATED AT: 122 NORTHERN AVENUE,
GARDINER, MAINE

DOCUMENTATION OF DISABILITY RELATED NEEDS

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

IF YOU HAVE EXISTING DOCUMENTATION OF HAVING THE SAME OR SIMILAR ACCOMMODATION PROVIDED TO YOU IN ANOTHER TEST SITUATION, YOU MAY SUBMIT SUCH DOCUMENTATION INSTEAD OF HAVING THIS PORTION OF THE FORM COMPLETED.

I have known_____since_____in my capacity as a
(test applicant) (date)

_____
(professional title)

The applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability, he/she should be accommodated by providing the following: (check all that apply)

- ☐ TAPED TEST
- ☐ LARGE PRINT TEST
- ☐ READER
- ☐ SCRIBE/AMANUENSIS
- ☐ EXTENDED TIME:
- ☐ TIME-AND-A-HALF
- ☐ DOUBLE TIME
- ☐ MORE THAN DOUBLE TIME (PLEASE JUSTIFY)
- ☐ SEPARATE TESTING AREA
- ☐ USE OF COMPUTER OR OTHER ADAPTIVE EQUIPMENT (PLEASE SPECIFY):

_____

OTHER (PLEASE SPECIFY):_____

_____

SIGNED:_____TITLE:_____

DATE:_____LICENSE # (if applicable):_____

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
(888) 577-6690 (HEARING IMPAIRED)

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

Name: **(applicant fees being paid for)**		
***Mailing Address*:** **(applicant fees being paid for)**		
City:	***State:***	***Zip Code:***
County:	***Telephone #: (_____)_____-_____***	
Name of cardholder: **(if other than applicant)**		
***Mailing Address*:** **(if other than applicant)**		
City:	***State:***	***Zip Code:***

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

☐ **Visa** ☐ **MasterCard**_____
Card number

Expiration date: _____/_____/_____ in the amount of: $_____

Signature: _____ **Date:** _____/_____/_____

OFFICE PHONE: (207)624-8674

PRINTED ON RECYCLED PAPER

FAX: (207)624-8637

(888) 577-6690 (HEARING IMPAIRED)
OFFICES LOCATED AT: 122 NORTHERN AVENUE,
GARDINER, MAINE

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
(888) 577-6690 (HEARING IMPAIRED)

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

REFERENCE FORM

EACH APPLICANT MUST HAVE ONE FORM COMPLETED BY THREE DIFFERENT COUNSELING PROFESSIONALS.
PLEASE PRINT OR TYPE

Name of applicant_____SS#_____-____-_____

Address_____City_____

State_____ZipCode_____Phone#(_____) _____- _____

Name of Counseling Professional_____

Address_____City_____

State_____Zip Code_____Phone#(_____) _____-_____

Professional title_____

Relationship to Applicant_____

It is required that each applicant shall demonstrate trustworthiness, ethical integrity and competence to engage in the practice of counseling in such a manner as to safeguard the interests of the public.

Do you believe that the above said applicant demonstrates trustworthiness, ethical integrity and competence? Yes_____ No_____

COMMENTS:_____

_____

_____ _____
Signature of Counseling Professional Date

Attachment 5

OFFICE PHONE: (207)624-8674

PRINTED ON RECYCLED PAPER

FAX: (207)624-8637

(888) 577-6690 (HEARING IMPAIRED)
OFFICES LOCATED AT: 122 NORTHERN AVENUE,
GARDINER, MAINE

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
(888) 577-6690 (HEARING IMPAIRED)

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

REFERENCE FORM

EACH APPLICANT MUST HAVE ONE FORM COMPLETED BY THREE DIFFERENT COUNSELING PROFESSIONALS.
PLEASE PRINT OR TYPE

Name of applicant_____SS#_____-____-_____

Address_____City_____

State_____ZipCode_____Phone#(_____) _____- _____

Name of Counseling Professional_____

Address_____City_____

State_____Zip Code_____Phone#(_____) _____-_____

Professional title_____

Relationship to Applicant_____

It is required that each applicant shall demonstrate trustworthiness, ethical integrity and competence to engage in the practice of counseling in such a manner as to safeguard the interests of the public.

Do you believe that the above said applicant demonstrates trustworthiness, ethical integrity and competence? Yes_____ No_____

COMMENTS:_____

_____

_____ _____
Signature of Counseling Professional Date

Attachment 5

OFFICE PHONE: (207)624-8674

FAX: (207)624-8637

(888) 577-6690 (HEARING IMPAIRED)
OFFICES LOCATED AT: 122 NORTHERN AVENUE,
GARDINER, MAINE

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
(888) 577-6690 (HEARING IMPAIRED)

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

REFERENCE FORM

EACH APPLICANT MUST HAVE ONE FORM COMPLETED BY THREE DIFFERENT COUNSELING PROFESSIONALS.
PLEASE PRINT OR TYPE

Name of applicant_____SS#_____-____-_____

Address_____City_____

State_____ZipCode_____Phone#(_____) _____- _____

Name of Counseling Professional_____

Address_____City_____

State_____Zip Code_____Phone#(_____) _____-_____

Professional title_____

Relationship to Applicant_____

It is required that each applicant shall demonstrate trustworthiness, ethical integrity and competence to engage in the practice of counseling in such a manner as to safeguard the interests of the public.

Do you believe that the above said applicant demonstrates trustworthiness, ethical integrity and competence? Yes_____ No_____

COMMENTS:_____

_____

_____ _____
Signature of Counseling Professional Date

Attachment 5

OFFICE PHONE: (207)624-8674

FAX: (207)624-8637

(888) 577-6690 (HEARING IMPAIRED)
OFFICES LOCATED AT: 122 NORTHERN AVENUE,
GARDINER, MAINE

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
(888) 577-6690 (HEARING IMPAIRED)

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

SUPERVISOR'S AFFIDAVIT: To be completed by supervisor in accordance with Chapters 2 through 6 of the Board's Rules

(Please print or type) New Applicant_____ or Conditionally licensed _____
Name of Applicant_____ SS#_____
Name of Approved Supervisor_____
Supervisor's License Title and Number_____
State of Licensure_____Original Date_____Expiration Date_____Years in Practice_____
Facility or Agency_____
Address_____City_____State_____
Zip Code_____County_____Telephone #_____

IN WHICH SPECIALTY AREA: (Please check)
Clinical Professional Counselor_____ Professional Counselor_____
Marriage and Family Therapist_____ Pastoral Counselor _____

SUPERVISION (List number of hours)
Individual_____ Group Supervision _____ Total number of supervision hours_____
SUPERVISED EXPERIENCE (List number of hours)*
Hours of direct counseling with individuals _____couples _____ families_____ groups _____
Total hours of direct counseling _____
Supervised experience in counseling other than the direct provision of counseling_____
Total number of hours of supervised experience_____

On the supervisor's stationary, signed and dated, please comment on the following:
1. Please describe the applicant's functions in terms of prevention, diagnosis and treatment of mental illness/disorders and psychosocial treatment: (**For the clinical licenses only – LCPC, LMFT, Pastoral)**.
2. Please state briefly the licensee's personal character, ethical conduct, and competence:
3. Please comment on the licensee's ability to function as a counselor (i.e. strengths and weaknesses):

I HEREBY ATTEST THAT THE ABOVE-NAMED APPLICANT IS/WAS UNDER MY SUPERVISON FROM THE PERIOD OF _____TO_____. I ATTEST THAT ALL INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.
Supervisor's Signature_____Date_____
Applicant's Signature_____Date_____

Attachment 6

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
(888) 577-6690 (HEARING IMPAIRED)

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

PROPOSED SUPERVISION PLAN
CONDITIONAL COUNSELOR LICENSURE

NAME OF APPLICANT:_____

S.S.#:_____-_____-_____

SUPERVISION PLAN

NAME OF SUPERVISOR:_____

SUPERVISOR'S LICENSE NUMBER:_____ S.S. #: _____

TITLE:_____ FIRST DATE OF ISSUE:_____

FACILITY OR AGENCY:_____

ADDRESS:_____

WORK TELEPHONE NUMBER:_____

SUPERVISION MUST EQUAL 1 HOUR/30 HOURS OF DIRECT COUNSELING SERVICE.

PLEASE DOCUMENT SPECIFIC PLANS THAT COVER THE FOLLOWING: (Use separate sheet if needed)

GOALS OF PLAN:

OBJECTIVES OF PLAN:

IF PROVIDING CLINICAL SUPERVISION FOR A CLINCIAL LICENSE - PLEASE FOCUS ON DIAGNOSIS AND TREATMENT:

I HEREBY ATTEST THAT THE ABOVE NAMED APPLICANT IS UNDER MY SUPERVISION FOR THE PERIOD BEGINNING_____. I ATTEST THAT ALL OF THE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

Supervisor's Signature_____ Date_____

Applicant's Signature_____ Date_____

OFFICE PHONE: (207)624-8674 FAX: (207)624-8637

(888) 577-6690 (HEARING IMPAIRED)
OFFICES LOCATED AT: 122 NORTHERN AVENUE,
GARDINER, MAINE

APPROVED SUPERVISOR FORM

NAME OF SUPERVISOR:_____

LIST THE NUMBER OF YEAR OF COUNSELING EXPERIENCE IN THE MODALITY (E.G. CLINICAL, MARRIAGE & FAMILY THERAPY, PASTORAL) WHICH YOU INTEND TO DO SUPERVISION:_____

DESCRIBE TRAINING RECEIVED IN COUNSELING SUPERVISION:_____

_____

_____

_____

_____

AND/OR

LIST THE NUMBER OF YEARS AND TYPES OF EXPERIENCES IN PROVIDING SUPERVISION TO MENTAL HEALTH PROFESSIONALS:_____

_____

_____

_____

_____

PROVIDE A SEPARATE WRITTEN STATEMENT DETAILING YOUR SUPERVISION PHILOSOPHY, ORIENTATION AND EXPERIENCE.

I HEREBY ATTEST THAT ALL THE INFORMATION ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Supervisor's Signature_____ Date_____

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
(888) 577-6690 (HEARING IMPAIRED)

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

DEGREE/INTERNSHIP VERIFICATION FORM

TO: Board of Counseling Professionals Licensure
Division of Licensing & Enforcement
35 State House Station
Augusta, ME 04333

Date: _____

Student Name: _____SS#_____

Institution: _____

Address: _____

_____

Degree Verification

Date of Graduation:_____Program:_____

Degree Awarded:_____Accreditation:_____

Concentration in which degree was awarded:_____

Internship Verification

Dates of Internship:_____Direct Client Contact Hours:_____ Total Contact Hours: _____

Internship Experience: Please indicate whether the counseling activities, setting, and supervisor were or were not clinical in nature ("clinical" is defined as the diagnosis and treatment of mental health disorders).

_____

_____

Signature of Person Verifying Degree/Internship:_____

Please Print Name:_____Title:_____

Department:_____Date:_____

Attachment 8

OFFICE PHONE: (207)624-8674

FAX: (207)624-8637

(888) 577-6690 (HEARING IMPAIRED)
OFFICES LOCATED AT: 122 NORTHERN AVENUE,
GARDINER, MAINE

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
(888) 577-6690 (HEARING IMPAIRED)

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

VERIFICATION OF LICENSURE IN OTHER STATE

DIRECTIONS TO APPLICANT:
Complete front portion of form and forward one to each state where you hold or have held a license to practice counseling, family therapy or pastoral counseling.

To: _____ I am applying for a license in the State of
State Board

Maine to practice as a _____. I was granted license # _____

license type _____ on _____ by the State of _____.

The Maine Board of Counseling Professionals Licensure requests that I submit verification that my license in the State of _____ is in good standing.

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Maine Board of Counseling Professionals Licensure. Your early attention is appreciated.

Signature: _____

Print Name: _____

Date: _____

Note: Because some States charge a fee to complete this form, you should check with each State before mailing.

(Page 2 to be completed by State)

OFFICE PHONE: (207)624-8674

PRINTED ON RECYCLED PAPER

FAX: (207)624-8637

(888) 577-6690 (HEARING IMPAIRED)
OFFICES LOCATED AT: 122 NORTHERN AVENUE,
GARDINER, MAINE

DIRECTIONS TO STATE BOARD: Please complete and return form to the following address:

MAINE BOARD OF COUNSELING PROFESSIONALS LICENSURE
#35 STATE HOUSE STATION
AUGUSTA, MAINE 04333

Name of Licensee: _____ License Type: _____

License #: _____ Date Issued: _____

License Current: Yes _____ No _____ Expiration Date: _____

Name of Exam Taken: _____ Date Exam Passed: _____

If no exam was taken, how was license obtained?
1. Grandfathered: _____ 2. Endorsement/Comity: _____ State: _____

What were the requirements for education and supervision at the time the license was issued?

_____

_____

Are there any pending complaints against this licensee?

Yes _____ No _____

Have there been any other actions taken against this licensee?

Yes _____ No _____

Explanation of above if answer is yes: _____

_____

_____

State Board Seal

Signature and Title: _____

Date: _____

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
(888) 577-6690 (HEARING IMPAIRED)

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

EXAMINATION

APPLICANTS WHO APPLY FOR EXAMINATION MUST SUBMIT ALL MATERIALS REQUIRED FOR LICENSURE BEFORE APPROVAL TO SIT FOR AN EXAMINATION WILL BE GRANTED. APPLICATION FOR EXAMINATION MUST BE SUBMITTED AT LEAST 90 DAYS PRIOR TO EXAM.

APPLICATION FEES MAY BE PAID BY CHECK. CHECKS ARE TO BE MADE PAYABLE TO THE "MAINE STATE TREASURER".

THE BOARD DOES NOT TAKE AN ADVISORY ROLE IN AN APPLICANT'S COURSE SELECTION. TO DETERMINE IF YOU HAVE MET THE MINIMUM REQUIRED CORE COURSES AND/OR IF YOU QUALIFY FOR LICENSURE, PLEASE CAREFULLY READ THE BOARD'S LAW AND RULES.

BOARD MEETINGS ARE USUALLY HELD THE FOURTH MONDAY OF EACH MONTH. IN ORDER TO BE REVIEWED, APPLICATIONS MUST BE RECEIVED AT LEAST 2 WEEKS PRIOR TO THE BOARD MEETING.

YOU WILL BE INFORMED OF THE RESULTS OF THE APPLICATION IN WRITING APPROXIMATELY TWO WEEKS AFTER THE BOARD MEETING. RESULTS OF THE APPLICATION REVIEW WILL NOT BE GIVEN OVER THE TELEPHONE.

OFFICE PHONE: (207)624-8674

FAX: (207)624-8637

(888) 577-6690 (HEARING IMPAIRED)
OFFICES LOCATED AT: 122 NORTHERN AVENUE,
GARDINER, MAINE

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
(888) 577-6690 (HEARING IMPAIRED)

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

REQUEST FOR EXAMINATION

APPLICANTS WHO APPLY FOR EXAMINATION MUST SUBMIT ALL MATERIALS REQUIRED FOR LICENSURE BEFORE APPROVAL TO SIT FOR AN EXAMINATION WILL BE GRANTED.

Please check the appropriate examination, fill in the information requested below and **return this form** will all other required application materials to the Maine Board of Counseling Professionals Licensure, 35 State House Station, Augusta, ME 04333.

Applicant for licensure as a Professional Counselor, Clinical Professional Counselor, or Pastoral Counselor:

(NCE)_____App. deadline: 10/18/2005 Exam Date: 01/21/2006
App. deadline: 01/16/2006 Exam Date: 04/22/2006
App. deadline: 04/17/2006 Exam Date: 07/22/2006
App. deadline: 07/17/2006 Exam date: 10/21/2006

Applicant for licensure as a Marriage and Family Therapist:

(PES)_____App. Deadline: 10/24/2005 Exam Date: 01/16/2006 to 02/11/2006
App. Deadline: 02/20/2006 Exam Date: 05/15/2006 to 06/10/2006
App. Deadline: 06/26/2006 Exam Date: 09/11/2006 to 10/07/2006

If you require special accommodations, please fill out the **Accommodation Request Form** and return it with your application materials.

.....

(Please Print)

NAME:_____

ADDRESS:_____

_____

DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

TELPEHONE #: work_____ home_____ DATE:_____

Attachment 10

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
(888) 577-6690 (HEARING IMPAIRED)

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

PREPARATION GUIDE FOR THE NATIONAL COUNSELOR EXAMINATION FOR LICENSURE AND CERTIFICATION (NCE)

The Official Guide for the NCE

- Describes the NCE
- Answers commonly asked questions about the NCE
- Suggests test-taking strategies
- Helps you assess your strengths & weaknesses regarding the subject matter covered by the exam
- Assists you in setting study priorities
- Lists over 40 potential resources for study and review
- Provides 134 practice examination questions
- Includes 38 former examination questions with justified responses

Developed and distributed by the National Board for Certified Counselors (NBCC), this guide will help you understand and prepare for the National Counselor Examination for Licensure and Certification (NCE). In an effort to reduce anxiety regarding the examination, we have tried to anticipate your questions about the nature of the examination and the testing procedures.

Price: $24.95 *(Price includes postage and handling)*

To order your preparation guide for the NCE, please detach the bottom portion of this form and mail it with your check, money order, or credit card information to:

NBCC/NCE Preparation Guide
3-D Terrace Way
Greensboro, NC 27403

Please send me _____ copy(s) of the PREPARATION GUIDE for the NATIONAL COUNSELOR EXAMINATION for LICENSURE and CERTIFICATION.

I am enclosing a check or money order payable to NBCC in the amount of _____, or please charge my: [ ] VISA [ ] MASTER CARD [ ] AMERICAN EXPRESS
Cardholder Name: _____Account #: _____

Expiration Date: _____ Amount Charged: _____

Send preparation guide to: Name _____

Address _____

_____

Telephone _____

Attachment 11

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
(888) 577-6690 (HEARING IMPAIRED)

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

Educational Requirements Worksheet for Licensed Pastoral Counselor

INSTRUCTIONS: Place the relevant course(s) from your transcripts into the appropriate category on the worksheet. The degree requirement is a minimum 20 semester hours or quarter-hour equivalent that satisfies each of the areas of study below. A course may not be used twice to fulfill more than one content area. NOTE: You must attach a college catalog, description or syllabus to substantiate the specific material included in each course listed on the worksheet.

Content Area	Course No.	Course Title	Credit Hours Qrt.	Credit Hours Sem.
A. Pastoral Theology and Psychology				
B. Testing and Measurement **or** Research Methods				
C. Studies in two of the following areas: 1. Basic pastoral care 2. Crisis Intervention 3. Cross-cultural Issues 4. Faith Development 5. Grief Counseling 6. Helping Relationships 7. History of Pastoral Care and Counseling 8. Hospital Ministry 9. Life Cycle Ritual 10. Psychology of Religion 11. Professional Orientation 12. Spiritual Direction 13. Human Growth and Development 14. Theories of Counseling				

Licensed Pastoral Counselor Educational Worksheet (Cont.)

D. Studies in at least one of the following: 1. Psychopathology 2. Clinical/pastoral assessment, and 3. Diagnosis and Treatment			
E. Professional Ethics			
F. Clinical Pastoral Education*			

*** Denotes that definition is contained on the following page.**

Educational Requirements for Licensed Pastoral Counselor

Chapter 5, Section 2(F)

Clinical Pastoral Education: One unit of 400 contact hours in clinical pastoral education in a program accredited by ACPE. This is a supervised internship in ministry to persons in crisis. Development of a pastoral identity and the integration of the person of the student chaplain in to the ministry is a central goal. A typical program of clinical pastoral education would include ministry to individuals and their families, written reports of visits reviewed in individual and/or group supervision, group dynamics sessions, and didactic seminars. The ministry is in the context of teamwork and other professionals.

OFFICE PHONE: (207)624-8674 FAX: (207)624-8637

PRINTED ON RECYCLED PAPER

(888) 577-6690 (HEARING IMPAIRED)
OFFICES LOCATED AT: 122 NORTHERN AVENUE,
GARDINER, MAINE

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
(888)577-6690 (HEARING IMPAIRED)

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

SUGGESTED FORMAT FOR DISCLOSURE STATEMENT

Disclosure Statement

A. Name, M.S.
Such-and-such Counseling Service
555 Main Street
City, Maine (207) 666-7777

B. **Degree:** Highest degree and related field of study
Licensure: Licensure: Please indicate here the license/registration type, original or renewal license, and the projected begin and end date of license term (2 year cycle). **(If conditionally licensed, please indicate).**
(Example: LCPC, original: 9/03 expiration: 9/05)

C. **Areas of competence** - I am trained for work with individuals, couples, and ....(continued concisely, but with a much detail as necessary to give clients an idea of the range of your skills and scope of your license/registration).

D. **Course of Action**- At the first interview ....(Include a description of your usual process of intake, assessment, and goal setting. If clinically licensed, please also explain your process for diagnosing and treating. This is designed to give your prospective client an idea of what to expect in counseling).

E. **Confidentiality** - A statement indicating the limits and scope of confidentiality. The following exceptions **must** be included:
1. Threat of serious harm to self or others.
2. Reasonable suspicion of child abuse, or abuse of elder or any incapacitated person.
3. Court order.
4. Voluntary release signed by client or guardian.
5. In defense against legal action or formal complaint which client makes before a court or regulatory board.
6. During supervisory consultations.

F. **Supervision** – A statement indicating supervision arrangement of counselor, when applicable.

G. **Fee schedule, hours of business, policy regarding third party payments** – explained with words that are clearly understood.

H. **Accountability** - A statement to the effect that "the practice of counseling is regulated by the Department of Professional and Finance Regulation, and complaints may be registered by contacting: Board of Counseling Professionals Licensure
35 State House Station
Augusta, ME 04333
(207) 624-8674

Attachment 16